# PATIENT REGISTRATION AND HEALTH HISTORY

TYSON FAMILY DENTAL

9431 Benbrook Blvd
Benbrook, Texas 76126
(817) 560-9300
www.TysonFamilyDental.com

Today's Date _____

## ABOUT THE PATIENT

Name _____ (Last) _____ (First) _____ (MI) _____ Mr Mrs Ms

☐ Male ☐ Female ☐ Married ☐ Single ☐ Minor Child ☐ Other Information

Social Security # _____ Date of Birth _____ Driver's License # _____ ST _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Ext. _____ Cell _____

Email _____

Employer Name _____ Address _____

Emergency Contact Name _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

## SPOUSE / GUARANTOR INFORMATION

The following information is for ☐ Patient's Spouse ☐ Guarantor (Person responsible for payment of account)

Name _____ (Last) _____ (First) _____ (MI) _____ Mr Mrs Ms

☐ Male ☐ Female ☐ Married ☐ Single ☐ Minor Child ☐ Other Information

Social Security # _____ Date of Birth _____ Driver's License # _____ ST _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Ext. _____ Cell _____

Employer Name _____ Address _____

***Please advise the business office of any additional insurance coverage***

## PRIMARY DENTAL INSURANCE

Subscriber Name _____ (Last) _____ (First) _____ (MI) Is subscriber a patient? ☐ Yes ☐ No

Subscriber's Date of Birth _____ ID/SS# _____ Group # _____

Subscriber's Home Address _____ City _____ State _____ Zip Code _____

Subscriber's Employer _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

## DENTAL HISTORY

Date of Last Dental Visit _____ Are you happy with the appearance of your teeth? ☐ Yes ☐ No

Does dental treatment make you nervous? ☐ Yes ☐ No If yes: ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever had a bad dental experience? ☐ Yes ☐ No Previous periodontal treatment? ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain _____

Please tell us how you heard about our office? ☐ Paient/Friend _____ ☐ Doctor ☐ Phone Book ☐ Yellow Pages ☐ Website ☐ Google Search ☐ Facebook ☐ Other _____

## MEDICAL HISTORY

How would you describe your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List your current physicians:

Name _____ Type _____ How Long? _____

Name _____ Type _____ How Long? _____

Date of last physical exam _____ Purpose _____

| | Check **No** | or **Yes** | Explain: |
|---|---|---|---|
| Are you aware of any changes in your general health in the last year? | ☐ | ☐ | |
| Have you been hospitalized for illness or surgery in the past two years? | ☐ | ☐ | |
| Have you been under a medical doctor's care during the past two years? | ☐ | ☐ | |
| Have you ever had excessive bleeding that required special treatment? | ☐ | ☐ | |
| Is there any history of diabetes in your family? | ☐ | ☐ | |
| Are you required to restrict your work activity in any way? | ☐ | ☐ | |
| Are you on a special or restricted diet of any kind? | ☐ | ☐ | |
| Do you smoke? | ☐ | ☐ | How Much? How long? |
| Do you use smokeless tobacco? | ☐ | ☐ | How much? How long? |

List all medications you are currently taking:

| | Name of Medication / Dosage | | Name of Medication / Dosage |
|---|---|---|---|
| 1. | | 16. | |
| 2. | | 17. | |
| 3. | | 18. | |
| 4. | | 19. | |
| 5. | | 20. | |
| 6. | | 21. | |
| 7. | | 22. | |
| 8. | | 23. | |
| 9. | | 24. | |
| 10. | | 25. | |
| 11. | | 26. | |
| 12. | | 27. | |
| 13. | | 28. | |
| 14. | | 29. | |
| 15. | | 30. | |

Please check any of the following medications you are allergic to:

☐ Penicillin ☐ Vibramycin ☐ Novocaine ☐ Tylenol ☐ Codeine ☐ Valium ☐ Other _____

☐ Erythromycin ☐ Sulfa Drugs ☐ Carbocaine ☐ Aspirin ☐ Demerol ☐ Barbituates _____

☐ Tetracycline ☐ Keflex ☐ Xylocaine ☐ Anesthetics ☐ Morphine ☐ Scopolamine _____

# MEDICAL HISTORY (Continued)

Indicate which of the following you have had or have at present. Check No or Yes to each item:

| | NO | YES | | NO | YES | | NO | YES |
|---|---|---|---|---|---|---|---|---|
| Latex Allergy | ☐ | ☐ | A Nervous Person | ☐ | ☐ | Psychiatric care | ☐ | ☐ |
| Heart Trouble | ☐ | ☐ | Artificial Joint (knee, hip) | ☐ | ☐ | Cancers or Tumors | ☐ | ☐ |
| Heart Disease or Attack | ☐ | ☐ | Kidney, Bladder Trouble | ☐ | ☐ | Radiation Treatment | ☐ | ☐ |
| Angina | ☐ | ☐ | Thyroid Disease | ☐ | ☐ | Chemotherapy | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Arthritis/Rheumatism | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Persistent Cough | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Contact Lenses | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Asthma | ☐ | ☐ | Hepatitis | ☐ | ☐ |
| Congenital Heart Lesions | ☐ | ☐ | Hay Fever | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Sinus Troubles | ☐ | ☐ | Jaundice | ☐ | ☐ |
| Scarlet Fever | ☐ | ☐ | Allergies or Hives | ☐ | ☐ | AIDS | ☐ | ☐ |
| Heart Pacemaker | ☐ | ☐ | Diabetes | ☐ | ☐ | Blood Transfusion | ☐ | ☐ |
| Heart Surgery | ☐ | ☐ | Stroke | ☐ | ☐ | Drug or Alcohol Addiction | ☐ | ☐ |
| Shortness of breath upon mild exertion | ☐ | ☐ | Frequent Thirst and/or Urination | ☐ | ☐ | Unintentional Weight Loss or Gain | ☐ | ☐ |
| Require more than two pillows to sleep | ☐ | ☐ | Epilepsy or Seizures | ☐ | ☐ | Phen-Fen for Weight Loss | ☐ | ☐ |
| Ankles Swell | ☐ | ☐ | Frequent Headaches | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Anemia | ☐ | ☐ | Fainting or Dizzy Spells | ☐ | ☐ | Hemophilia | ☐ | ☐ |
| Sickle Cell Disease | ☐ | ☐ | | | | | | |

Females:

| | | | | | |
|---|---|---|---|---|---|
| Are you pregnant? | ☐ | ☐ | Through menopause? | ☐ | ☐ |
| Taking birth control pills? | ☐ | ☐ | Taking Hormone Medication | ☐ | ☐ |

Do you have any medical condition / disease Not listed above that we should know about? ☐ No ☐ Yes

If Yes, please explain: _____

_____

_____

_____

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will inform the doctor on or before my next appointment without fail.*

_____ _____ _____ _____

Patient's Signature Date Doctor's Signature Date